Virginia Office of Emergency Medical Services
Prehospital and Interhospital
State Trauma Triage Plan

Virginia Department of Health
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Appendices

Executive Summary.

Under the *Code of Virginia* **§** *32.1-111.3*, The Office of Emergency Medical Services (OEMS) acting on behalf of the Virginia Department of Health has been charged with the responsibility of developing a Statewide Trauma Triage Plan. This plan is to include prehospital and interhospital patient transfers.

The *Code* states that the State Trauma Triage Plan shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The *Code* further directs the collection of data through The PPCR Program and State Trauma Registry and protects its ability to be used by Trauma Committees that report to the Governors EMS Advisory Board.

In accordance with § 32.1-116.2. of the *Code*, any such data or information in the possession of or transmitted to the Commissioner (OEMS as the designee), the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

The Virginia Trauma System is an inclusive system, but all hospitals participate in the Trauma Triage Plan. Establishing a comprehensive statewide emergency medical care system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality.

These goals can be achieved by reducing the time period that acutely injured patients are identified and assisted in reaching definitive high quality trauma care. A coordinated effort between ground and air prehospital resources, as well as hospitals, whether trauma designated or not, can lead to getting the right patient to the right hospital, in the shortest amount of time possible, while maximizing resources.

This document will provide a uniform set of proposed criteria for prehospital and inter hospital triage and transport of trauma patients. The development and monitoring of these criteria is performed by the State Trauma Triage Performance and Improvement Committee which is a sub committee of the Governors Advisory Board's Trauma System Oversight and Management Committee. The State Office of EMS is the enforcement body for the State Trauma Triage Plan.

Recognizing the complexity of Virginia's variability in demographics and geography, the State Trauma Triage Plan has been designed to set a template for the Regional EMS Councils to develop, monitor and revise a regionalized trauma triage plan. Through regionalized Trauma Performance Improvement Committees issues in trauma care on scene, in transit and within hospitals can be addressed.

These improvements can be accomplished by conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of healthcare providers involved in trauma care. These criteria are not meant to supersede applicable laws such as EMTALA and HIPAA.

Trauma Patient Transport & Transfer Criteria

Trauma Victim:
A person who has acquired serious injuries and or wounds brought on by either an outside force or an outside energy. These injuries and or wounds may affect one or more body systems by blunt, penetrating or burn injuries. These injuries may be life altering, life threatening or ultimately fatal wounds.

Two-tiered System for the recognition of a trauma patient.

- Initial triage in the prehospital setting.
- Secondary triage at local hospitals.

The purpose of the Statewide Trauma Triage Plan is to establish prehospital and hospital criteria for the purpose of identifying the trauma patient. The Regional Trauma Triage Plans should identify the best point of entry plan for these patients. Many factors such as geography, hospital capabilities, air medical services and others, will help to guide where the identified trauma patient will be transported or transferred to.

PREHOSPITAL CRITERIA

Adult Patient	Pediatric Patient
Respiratory* • Respiratory Rate <8 or >30 • Assisted Ventilation • Partial or complete airway obstruction • Unable to establish or maintain airway • Intubation	**Respiratory*** • Requires constant observation for patency • O2 administration, or assisted ventilations • Partial or complete airway obstruction • Unable to establish or maintain airway • Intubation
CNS • Unconscious/Unresponsive • Does not follow commands • Unable to move extremities	**CNS** • Unconscious/Unresponsive • Unable to move extremities
Hemodynamics • Systolic blood pressure <90 (with signs & symptoms of shock) • Heart Rate >120 (with signs & symptoms of shock) • Uncontrolled Bleeding • Extremities with uncontrolled bleeding, loss of pulse and/or amputation	**Hemodynamics** <10 Kg. (22#) 11-20 Kg. (24-44#) >20 Kg. (>40#) Systolic BP <50 Systolic BP ,70 Systolic BP ,90 Poor peripheral Pulses Poor peripheral Pulses Poor peripheral Pulses Poor perfusion Poor perfusion Poor perfusion Uncontrolled Bleeding Uncontrolled Bleeding Uncontrolled Bleeding • Uncontrolled Bleeding • Extremities with uncontrolled bleeding, loss of pulse and/or amputation
Penetrating Injury • Head • Neck • Chest, abdomen	**Penetrating Injury** • Head • Neck • Chest, abdomen
Special Considerations • Trauma in pregnancy (≥ 24 weeks gestation) • Geriatric • Bariatric • Special Needs Individuals	

*Prehospital providers and local hospitals need to be aware of regional and/or local protocols that deal with issues of where to transport patients with uncontrolled airway, uncontrolled hemorrhage or if there is CPR in progress in the trauma patient.

HOSPITAL CRITERIA

Adult Patient	Pediatric Patient
	Any pediatric patient with a Pediatric Trauma Score ≤ 6. * See pediatric trauma score below
Respiratory • Bilateral thoracic injuries • Significant unilateral injuries in pt's >60 (e.g. pneumothorax, hemo- pneumothorax, pulmonary contusion, >5 rib fractures). • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease. • Respiratory compromise requiring intubation. • Flail chest.	**Respiratory** • Bilateral thoracic injuries • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease. • Flail chest.
CNS • Unable to follow commands • Open skull fracture • Extra-axial hemorrhage on CT, or any intracranial blood. • Paralysis • Focal neurological deficits • GCS ≤ 12	**CNS** • Open skull fracture • Extra-axial hemorrhage on CT. • Focal neurological deficits
Cardiovascular • Hemodynamic instability as determined by the treating physician. • Persistent hypotension. • Systolic B/P (<100) without immediate availability of surgical team.	
Injuries • Any penetrating injury to the head, neck, torso or extremities proximal to the elbow or knee without a surgical team immediately available*. • The combination of trauma with burns. • Significant abdominal to thoracic injuries in patients where the physician in charge feels treatment of injuries would exceed capabilities of the medical center.	**Injuries** • Any penetrating injury to the head, neck, chest abdomen or extremities proximal to the knee or elbows without a surgical team immediately available. • Combination of trauma with burn injuries • Any injury or combination of injuries where the physician in charge feels treatment of the injuries would exceed the capabilities of the medical center.
Special Considerations • Trauma in pregnancy (≥ 24 weeks gestation) • Geriatric • Bariatric • Special Needs Individuals	

* Regional Trauma Triage Plans should address the transfer of trauma patients to an appropriate designated trauma center.

Pediatric Trauma Score ≤6.

COMPONENT	+2	+1	-1
Size	Child/adolescent, >20 Kg.	Toddler, 11-20 Kg.	Infant, <10 Kg.
Airway	Normal	Assisted O2, mask, cannula	Intubated: ETT, EOA, Cric
Consciousness	Awake	Obtunded; loss of consciousness	Coma; unresponsiveness
Systolic B/P	>90 mm Hg; good peripheral pulses, perfusion	51-90 mm Hg; peripheral pulses, pulses palpable	<50 mm Hg.; weak pr no pulses
Fracture	None seen or suspected	Single closed fracture anywhere	Open, multiple fractures
Cutaneous	No visible injury	Contusion, abrasion; laceration <7 cm; not through fascia	Tissue loss; any GSW/Stabbing; through fascia

BURN RELATED INJURIES

The American Burn Association has identified the following injuries that usually require referral to a burn center.

- Partial thickness and full thickness burns greater than 10% of the total body surface area (BSA) in patients under 10 or over 50 years of age.
- Partial thickness burns and full thickness burns greater than 20% BSA in other age groups.
- Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints.
- Full-thickness burns greater than 5% BSA in any age group.
- Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications).
- Significant chemical burns.
- Inhalation injuries.
- Burn injury in patients with pre-existing illness that could complicate management, prolongs recovery, or affects mortality.
- Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center.
- Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities.
- Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect.

Medical Control
Major Trauma Transport Considerations

Regional Patient Care Protocols must address transport considerations. Each region is unique in its availability of trauma resources. Consideration should be given to the hospitals that are available in the region and the resources they have available to trauma patients when developing a point of entry plan.

Consideration should also be given to prehospital resources including, the level of care available by the ground EMS crews, and the closest Medevac service available at the time of the incident, and other conditions such as transport time and weather conditions.

*(*Prehospital providers and local hospitals need to be aware of regional and/or local protocols that deal with issues of where to transport patients with uncontrolled airway, uncontrolled hemorrhage or if there is CPR in progress in the trauma patient.)*

Regional EMS Mass Casualty Incident (MCI) Plans and Disaster/Weapons of Mass Destruction (WMD) Plans

Both prehospital and hospital providers should become familiar with other related Regional plans. These plans represent a tiered response to growing numbers of patients:

- MCI Plan
- Disaster/WMD Plans
- Surg Capacity Plans

The plans build upon one another. The Trauma Triage Plan is intended to guide treatment for a smaller number of patients that can be managed by resources available during normal day to day operations. MCI Plans provide additional guidance to agencies, municipalities and medical facilities when their normal resources are being strained. Surg plans are being developed to meet the need of large scale events that may require caring for hundreds even thousands of patients.

Criteria for Medevac Transport (when available and criteria are met)

Scene Transports by Helicopter

1. All patients transported by air must meet the clinical triage criteria for transport the closest appropriate Level I or II trauma center or burn center. The closest appropriate helicopter should be utilized and transport the trauma patient to the closest appropriate hospital.

2. Patient requires a level of care greater than can be expected by the local ground provider.

1 or 2 ABOVE, <u>PLUS</u> ANY OF THE FOLLOWING:

a. Difficult access situations:
   1. Wilderness rescue.
   2. Ambulance egress or access impeded at the scene by road conditions, weather or traffic.

b. Time/distance factors:
    1. ETA to a local hospital by ground greater than ETA to the trauma center by helicopter.
    2. Patient extrication time >20 minutes.
    3. Utilization of ground ambulance leaves local community without ground transport coverage.

Inter-hospital Transports by Helicopter

1. All trauma patients transported by air must meet the clinical trauma triage criteria for transport to the closest Level I or Level II trauma center or burn center

2. Patient requires a level of care greater than can be provided by the local hospital.

3. Patient requires time critical intervention, out of hospital time needs to be minimal, or distance to definitive care is long.

4. Utilization of local ground ambulance leaves local community without ground ambulance coverage.

Trauma Triage Quality Monitoring

(Performance Improvement Committees)

The Office of EMS will coordinate a program for monitoring the quality of trauma care. This program will provide for the collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the Prehospital Patient Data Reporting (PPDR) Program and the Trauma Registry. An effective quality improvement process is essential to improve trauma patient outcomes.

The State Trauma Performance Improvement (TPI) Committee will also review such data on a quarterly basis and report its findings to the Health Commissioner and the EMS Advisory Board. The program for monitoring and reporting the results of trauma services data analysis will be the sole means of encouraging and promoting compliance with the trauma triage criteria.

The Office of EMS, acting on behalf of the Commissioner of Health, will report aggregate findings of the analysis annually to each Regional EMS Council. The findings of the report shall be used by the Councils to improve their Regional Trauma Triage Plan, including triage, transport and trauma center designation criteria.

A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

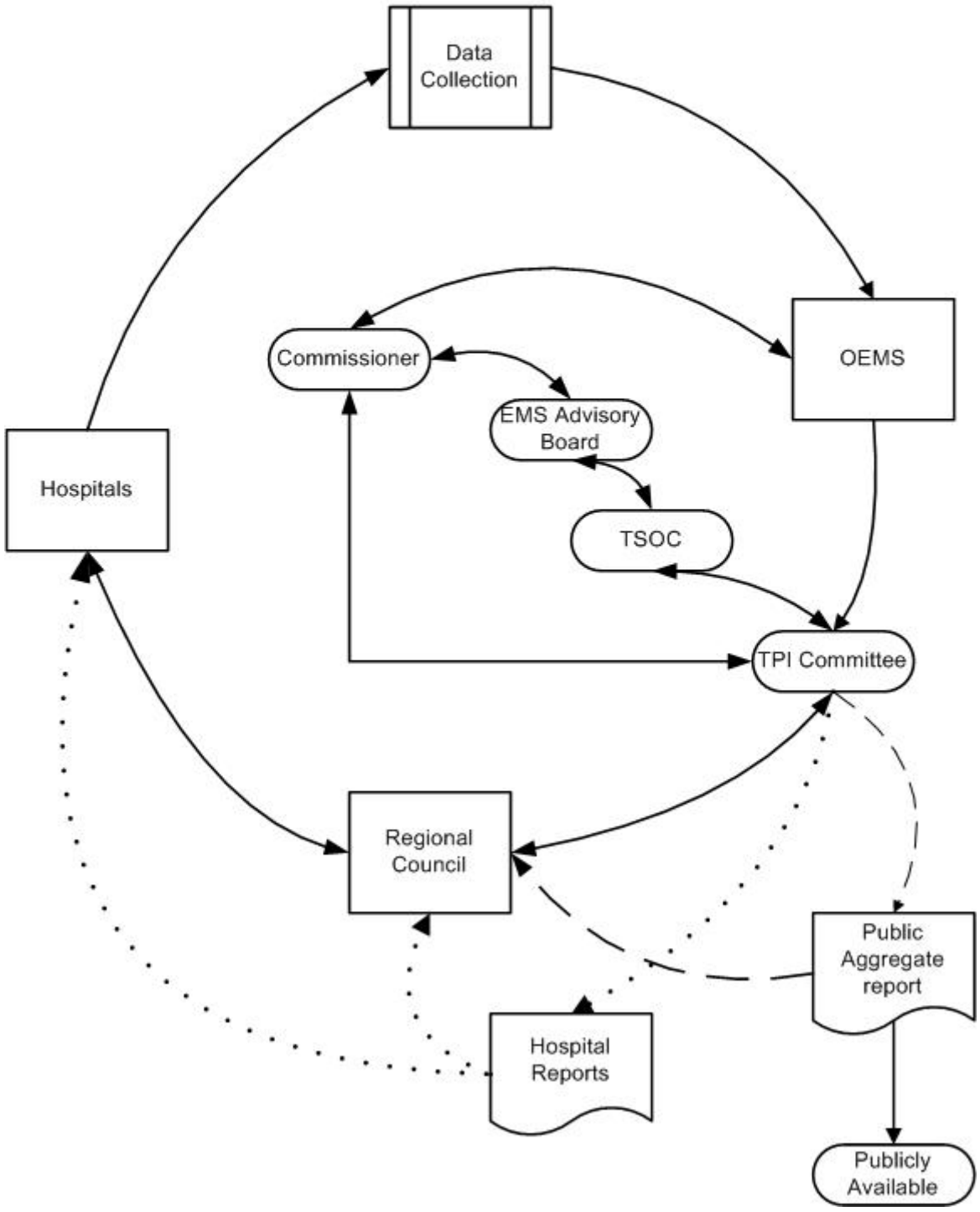
The program will ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and will give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings as is written in the *Code of Virginia*, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

Methodology:
The Office of EMS biostatistician will provide a retrospective analysis of the previous calendar year's trauma triage activities to the EMS Advisory Board, by the Board's August quarterly meeting. This same report will be provided to the Regional Councils for use in satisfying their obligation to provide TPI initiatives for the fiscal year.

The Regional Councils should provide the Office of EMS with a deliverable in June of each year that reflects the previous fiscal year's TPI activities. At minimum the deliverable should provide the following: 1) topic of measurement 2) methodology of measurement 3) action taken following data analysis (loop closure).

Schematic of Trauma Performance Improvement



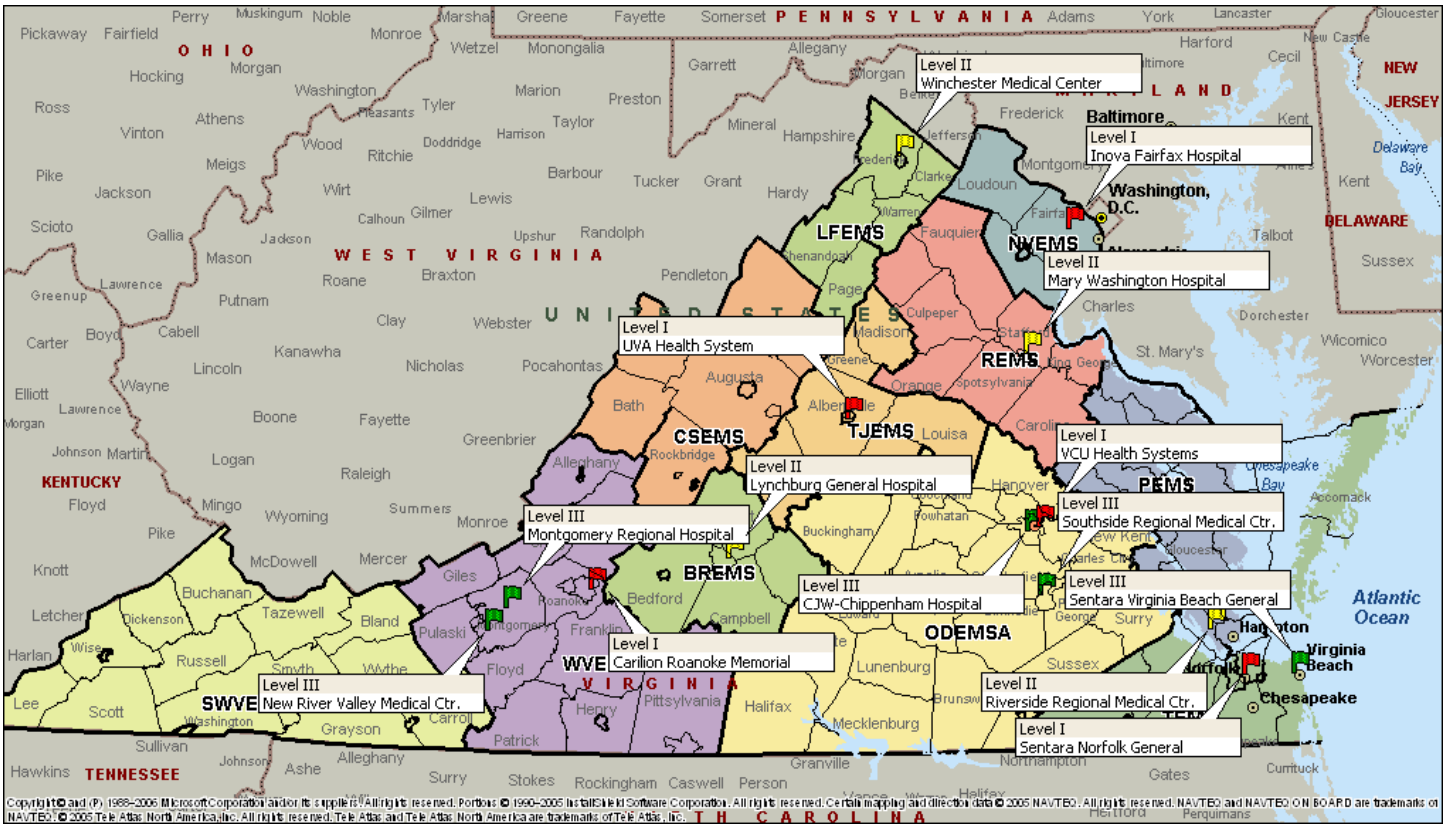
Appendix A

Regional Trauma Plan Requirements

Each Regional EMS Council will be responsible for maintaining a Regional Trauma Triage Plan and updating the plan on an annual basis. The Regional Trauma Triage Plan should be developed in the outline below.

- Cover Page
- Executive Summary (should incorporate the State Trauma Triage Plan Executive Summary and additional information needed for the individual Regional Council)
- Definition of a Trauma Victim – from state plan, Trauma Patient Transport & Transfer Criteria section.
- Trauma Patient Transport & Transfer Criteria; To include prehospital trauma patient criteria for both adult and pediatric patients, interhospital trauma patient transfer guidelines, burn injury and Medevac guidelines for trauma patients. Regions should include when the MCI plan is to be initiated in place of the trauma triage plan.
- Regional point of entry plan that identifies transport considerations for the trauma patient that is consistent with the regions Medical Control and Trauma Patient Care Protocols.
- Performance Improvement Process Schematic accompanied by a clearly documented method for EMS providers, agencies and hospitals to enter a patient and/or other concerns into the Trauma PI process (regulation and compliance issues should be referred to the State TPI Committee or OEMS Regulation & Compliance Program as a last resort).
- Trauma center description (names, locations and Levels of trauma center designation with a description of the services offered at the different levels of trauma centers).
- Regional Demographics/Trauma Care Resources. This section should provide region specific information such as, the geography, demography, trauma centers, hospitals, burn centers, EMS agencies, personnel, EMS vehicles, communications and trauma related education for both providers and the public within the region.
- The *Code of Virginia* § 32.1-111.3. This section of the *Code* clearly documents the ability for EMS agencies, hospitals and entities such as the Regional Councils to exchange patient care information for the purposes of quality monitoring. Patient care information can be exchanged by anyone acting under the authority of the Health Commissioner or the EMS Advisory Board without violating requirements of HIPAA.
- Should include notation of the current EMS Regulation/s related to compliance with the Trauma Triage Plan.

Appendix B



Level 1 Trauma Centers

Carilion Roanoke Memorial Hospital
Bellevue @ Jefferson Streets, Roanoke

Inova Fairfax Hospital
3300 Gallows Road, Falls Church

Sentara Norfolk General Hospital
600 Gresham Drive, Norfolk

UVA Medical Center
1224 West Main Street, Charlottesville

VCU Medical Center
12th & Marshall Streets, Richmond

Level 2 Trauma Centers

Lynchburg General Hospital
1901 Tate Springs Road, Lynchburg

Mary Washington Hospital
1001 Sam Perry Boulevard, Fredericksburg

Riverside Regional Medical Center
500 J. Clyde Morris Boulevard, Newport News

Winchester Medical Center
1840 Amherst Street, Winchester

Level 3 Trauma Centers

Carilion New River Valley Medical Center
2900 Lamb Circle, Christiansburg

CJW Medical Center, Chippenham
7101 Jahnke Road, Richmond

CJW Medical Center, Johnston-Willis
1401 Johnston-Willis Drive, Chesterfield

Montgomery Regional Hospital
3700 South Main Street, Blacksburg

Sentara Virginia Beach General Hospital
1060 First Colonial Road, Virginia Beach

Southside Regional Medical Center
801 South Adams Street, Petersburg

Regional EMS Councils

- **Blue Ridge EMS Council** (BREMS)
  1900 Tate Springs Road, Suite 14
  Lynchburg, VA 24501
- **Lord Fairfax EMS Council** (LFEMSC)
  117 W Boscawen Street
  Winchester, VA 22601
- **Old Dominion EMS Alliance** (ODEMSA)
  1463 Johnston-Willis Drive
  Richmond, VA 23235
- **Rappahannock EMS Council** (REMS)
  2301 Fall Hill Avenue, Suite 101
  Fredericksburg, VA 22401
- **Tidewater EMS Council** (TEMS)
  855 W. Brambleton Avenue
  Norfolk, VA 23510-1001
- **Western Virginia EMS Council** (WVEMS)
  3229 Brandon Avenue, Suite 7
  Roanoke, VA 24018-1547
- **Central Shenandoah EMS Council** (CSEMS)
  2312 West Beverley Street
  Staunton, VA 24401
- **Northern Virginia EMS Council** (NOVA)
  44983 Knoll Square, Suite 75
  Ashburn, VA 20147
- **Peninsulas EMS Council** (PEMS)
  PO Box 2348,
  Gloucester, VA 23061
- **Thomas Jefferson EMS Council** (TJEMS)
  2205 Fontaine Ave., Suite 302
  Charlottesville, Virginia 22903
- **Southwest Virginia EMS Council** (SWEVAEMS)
  329 West Main Street
  Abingdon, Virginia 24210

Appendix C
Trauma Center Designation's Defined

Level I

Level I trauma centers have an organized trauma response and are required to provide total care for every aspect of injury, from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research and system planning.

Level II

Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. The specialty requirements may be fulfilled by on call staff, that are promptly available to the patient. Due to some limited resources, Level II centers may have to transfer more complex injuries to a Level I center.
Level II centers should also take on responsibility for education and system leadership within their region.

Level III

Level III centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, emergency operations and also arrange for the transfer of the patient to a facility that can provide definitive trauma care.
Level III centers should also take on responsibility for education and system leadership within their region.

Appendix D

Virginia Demographics

Residents of Virginia	7.3 million
Square Miles in Virginia	42,769
Localities	135
Trauma Centers in Virginia	
Level I	5
Level II	3
Level III	6
Licensed Hospitals	87
Regional EMS Councils	11
Licensed EMS Agencies	750
Medevac Agencies	13
EMS Vehicles	3,600
EMS Providers	33,143
First Responders	1,572
BLS Providers	23,709
ALS Providers	7,862

Appendix E

***EMS* Regulation**

12 VAC 5-31-390. Destination/trauma triage.
An EMS agency shall participate in the Regional Trauma Triage Plan established in accordance with § 32.1-111.3 of the Code of Virginia.

§ 32.1-111.3. Statewide emergency medical care system.

A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan which shall incorporate, but not be limited to, the plans prepared by the Regional Emergency Medical Services Councils. The Board shall review the Plan triennially and make such revisions as may be necessary. The objectives of such Plan and the system shall include, but not be limited to, the following:
1. Establishing a comprehensive statewide emergency medical care system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;
2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;
3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;
4. Promoting continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;
5. Improving the quality of emergency medical care delivered on site, in transit, in hospital emergency departments and within the hospital environment;
6. Working with medical societies, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;
7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services;
8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;
9. Establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;
10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;
11. Establishing a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter;
12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.); and

13. Establishing a registration program for automated external defibrillators, pursuant to § 32.1-111.14:1.
B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:
1. A strategy for implementing the statewide Trauma Triage Plan through formal regional trauma triage plans developed by the Regional Emergency Medical Services Councils which can incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be implemented by July 1, 1999, upon the approval of the Commissioner.
2. A uniform set of proposed criteria for prehospital and inter hospital triage and transport of trauma patients, consistent with the trauma protocols of the American College of Surgeons' Committee on Trauma, developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.
3. A program for monitoring the quality of care, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter, the Patient Level Data System, and mortality data. The Emergency Medical Services Advisory Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The first such report shall be for the quarter beginning on July 1, 1999. The Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the trauma triage criteria. The Commissioner shall report aggregate findings of the analysis annually to each Regional Emergency Medical Services Council, with the first such report representing data submitted for the quarter beginning July 1, 1999, through the quarter ending June 30, 2000. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region. The Advisory Board shall ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and shall give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria. The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Advisory Board, or any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.
C. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of

this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle or other form of conveyance.
(1996, c. 899; 1997, c. 321; 1998, c. 317; 1999, c. 1000.)